

City Of Watertown, New York
Request for Reimbursement
CLAIM FORM

NAME:	Last	First	MI	SS#	
ADDRESS:	Street	City	State	ZIP	PHONE ()



Please check if this is a new address. Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.

Information below must be completed

MEDICAL EXPENSE CLAIMS

Date of Service MM/DD/YY	Patient Name	Patient's SS#	Relationship	Name of Provider	Description of Service	Claim Amount
						\$
						\$
						\$
						\$
						\$
						\$
						\$
						\$
<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="border: 1px solid black; width: 50px; height: 20px; margin-bottom: 5px;"></div> <div>CHECK IF ADDITIONAL CLAIM FORMS ARE ATTACHED</div> <div>Total:</div> </div>						\$

DEPENDENT CARE CLAIMS

Date of Service From To	Dependent Name	Age	Dependent Care Provider Name	Dependent Care Provider Address	Provider Tax Id#/SS#	Claim Amount
						\$
						\$
						\$
						\$
Total:						\$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under Code 213{d}. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return. These expenses are for medical care excluding cosmetic purposes, are not incurred for general health purposes, and do not constitute toiletries. I also understand that I may be asked to provide further details about some expenses {e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition or a more detailed certification}

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** ____/____/____

FOR FASTEST REIMBURSEMENT, FAX TO (315) 779-9925

OR MAIL TO: BENEFIT SERVICES GROUP
P.O. Box 6920 , WATERTOWN, NY 13601